IHS GPRA Indicator Development

GPRA Coordinating Committee, composed of

- Area Representatives
- I/T/U Representatives
- Interested Parties
- Clinical Groups

Routine GPRA Stakeholder meetings to review, discuss, edit, add, or delete: indicator, content in indicator, or calculation (logic)

Timeframes:

- Process begins two years prior to fiscal year
- Proposed indicators presented to HHS for comment several months prior to start of fiscal year
- Completion of review process by HHS at least six months before fiscal year

Indicators must be coordinated with:

- President of the United States Agenda
- HHS Directives
- IHS Goals
- Area Office Initiatives
- Health People 2010
- National Health Promotion and Disease Prevention Objectives

HHS and OMB are pushing for:

- shorter and simpler GPRA plans
- more outcome and fewer process measures
- more explicit linkages between budget and performance
- more benchmarking to industry standards (HEDIS, HP 2010, etc.)

Public Health approach to IHS indicator development

- Links resources to activities or processes
- Reduces risk factors for disease
- Improves outcomes
- Assures that performance indicators are specifically linked to health problems of AI/AN population

GPRA links health care process to outcomes by:

- Primary prevention: Prevention of disease or condition before it occurs
- Secondary prevention: Reduction of morbidity and mortality associated with disease or condition, after it occurs
- Early interventions: Early recognition and treatment versus targeting end point problems, e.g. strokes

IHS Internal Process

1. Indicators will be developed and edited periodically by the GPRA Coordinating Committee. This meeting will include appropriate representation from the clinical community, as well as the I/T/U spectrum. In addition, subject matter experts in each field (from outside the agency who are familiar with IHS) will be invited to participate in the indicator proposal process.
2. Once an indicator is proposed, the indicator will be assigned to the appropriate people for indicator development (see indicator criteria below).
3. The results of the indicator development process will be distributed to a group of subject matter experts. This group will recommend the inclusion of this indicator in the national indicator set, as well as any appropriate modifications to the proposed indicator.
4. The proposed indicator data query logic will be tested and validated against the national data warehouse. Potential problems will be identified and resolved. If these problems are not resolvable, the indicator will be returned to the appropriate working group for further refinement and/ or rejection.
5. Final acceptance of any indicator will rest with the national GPRA coordinator.

Indicator Criteria

Indicators should be developed based upon this modified World Health Organization (WHO) format. This format details specific information that should be assessed and included with each proposed indicator. These specifications are as follows:

1. **Definition of indicator** – what is the indicator? This field helps define the indicator
2. **Issue** – defines where the indicator belongs in the health indicator set. Examples include air quality, housing, workplace, and health. This area should be used to justify why this indicator has been developed. It should also detail how this indicator will help monitor and/ or change the local, district, or national health status.
3. **Evidence Base/ Health Outcome –** is there clinical evidence that supports this measure? Is the process of care linked to this outcome indicator? What is the evidence? What peer-reviewed groups recommend this indicator? Why?
4. **Cost-Effectiveness Analysis** – is a cost-effectiveness analysis available for this indicator? Are the CEA population demographics similar to our service population?
5. **Targeted Population** – is the denominator composed of a high risk group?
6. **Underlying definitions and concepts** – what the indicator is based upon. This field specifically defines words and/ or phrases within the definition of the indicator. Examples include the definition of an infant (age greater than one month and less than one year), definition of an accident, and/ or definition of a population.
7. **Specification of data needed** – includes the denominator of the indicator. For example, the total number of live births in the indicator year, or the total number of hospital discharges within a specified time period would be defined in this field. ICD codes or any other standard terminology that will be queried from a database should be included here.
8. **Data sources, availability and quality** – list the data sources that can be utilized to obtain this information; comment on the availability and quality of the data that is expected. If the

data is to be estimated, comment on the quality of this data. One should consider reliability, accuracy and reproducibility when commenting on data quality. Specifically list data sources for sites that are not on RPMS

9. **Documentation of patient exceptions** – does the queried data system allow us to document patient exceptions? If no, is there a way to eliminate inappropriate patients from the data set?
10. **Defined Data Query Logic**—how will the data set be queried? What codes will be used to obtain the necessary information?
11. **Computation** – how the results will be calculated; is there a formula that will be used for this calculation? Who developed the formula? If the formula is derived, what is it based on? How accurate is the formula?
12. **Units of measurements**- number of x per thousand, or some other denominator
13. **Scale of application** – local, regional, national or international; include comments on applicability to different levels, if appropriate
14. **Interpretation**- how should the indicator be interpreted; what will the result mean, and how can it be used in decision-making. What will changes in the indicator mean?
15. **Linkage with other indicators** - Is this indicator dependent upon multiple variables? Are there other factors that influence this indicator? Are these other factors identifiable? This section can include a list of the following:
    - pressure (What affects the indicator),
    - exposure; effect (the effect of the pressure and Exposure), and
    - action (what action should be taken to change the outcome)
16. **Related internal data indicators** – list any other indicators that are currently collected that are related to this indicator
17. **Related External Data Indicators** – list other groups that use this or similar indicators to monitor quality of care
18. **Recipient of the indicator** – who should receive the results of the indicator? Why? Is there any specific action expected based upon their receipt of the indicator? If there is, detail what you expect this action to be
19. **Resource Requirements / Availability** – what are the resources needed to measure this indicator; what are the resources needed to achieve this indicator? Does the agency have these resources at the current time?
20. **Responsible Person**—who is responsible for this indicator at the national level? At the field level? Who is responsible for ensuring that the reporting of this indicator is done in a timely and appropriate manner?